



AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION WORKFORCE HEALTH

PATIENT NAME: _____ PREVIOUS NAMES, IF APPLICABLE: _____

ADDRESS: _____ DATE OF BIRTH: _____

DATE/TIME OF REQUEST: _____ PHONE: () - _____ PEOPLESOFT ID: _____

I authorize the use and disclosure of my protected health information as described in this authorization. I understand that my authorization is voluntary and that I may revoke this authorization at any time by presenting a written request to the office of the practitioner who furnishes individual coaching and disease management wellness services to me. I understand that the revocation will not apply to information that has already been released.

Information Disclosed From: ☐ Froedtert Health, Inc. (dba Workforce Health)

On behalf of: _____
W129 N7055 Northfield Drive, Bldg. B
Menomonee Falls, WI 53051

Or

☐ Froedtert Memorial Lutheran Hospital, Inc.

9200 West Wisconsin Avenue
Milwaukee, WI 53226

Information Disclosed To: _____

Physician name and fax number

Records that may be Disclosed: All records created, received, used, or maintained by Froedtert Health, Inc. (dba Workforce Health) or Froedtert Memorial Lutheran Hospital, for, and resulting from, the provision of coaching, health risk reduction, disease management and/or other services; contacting me to discuss my health, including providing general and risk-related health information, and/or follow-up care; any available claims data from any health insurance plans in which I am a participant, beginning on the first date such services are furnished to me and all dates on which I receive such services.

I understand my records may include references to treatment of alcohol and drug abuse, psychiatric care, developmental disabilities, HIV test results/acquired immune deficiency syndrome and intoxication test results, and that these records may be released under this authorization unless I give written instructions not to release them.

Purpose of Disclosure: Release lab results from wellness program to physician.

I understand that if the persons I authorize to receive the protected health information described on this form are not health plans or health care providers or clearinghouses they may further disclose the protected health information and it may no longer be protected by federal privacy law. Unless I revoke this authorization, it will remain in effect until the company sponsoring my treatment no longer covers such services for me.

SIGNATURE _____ DATE _____

Form of Consent #5- Form of HIPAA Authorization of Disclosure of PHI (Brown)

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